Authorization to Release Medical Information
Arundel Pediatrics- Arnold

605 Global Way, Ste 119
Linthicum, MD 21090
Phone 410-789-PEDS
Fax 410-636-4264

1460 Ritchie Highway, Ste 209
Arnold, MD 21012
Phone 410-789-PEDS
Fax 410-757-7068

Patient Information:

Print Name: _____ **Date of Birth:** _____
Address: _____ **Phone #** _____

Healthcare Information coming from:

Arundel Pediatrics
1460 Ritchie Highway, Ste 209
Arnold, MD 21012
Phone 410-789-PEDS
Fax 410-757-7068

Please release my healthcare information to:
Name of Facility/Provider:
_____
Address _____
_____
Phone _____
Fax _____

Information to be released (please check the appropriate box):

- ❑ All medical records to include items below
- ❑ The most recent 2 years of pertinent information (chart notes, labs, ultrasounds, and special test)
- ❑ Maternal medical history
- ❑ Family Medical history
- ❑ Specific information (please specify) _____

Purpose for which disclosure is needed (please check appropriate box):

- ❑ I am transferring my care to a new Primary Care Provider
- ❑ Legal investigation
- ❑ Insurance Carrier Issues
- ❑ Referral to Specialist
- ❑ Person/Other (please specify) _____

Patient Authorization

I understand that the information in my health record may include information relating to physical and/or mental illness, Sexually related issues, Sexually Transmitted Diseases (STD's), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). If requested in the future, Arundel Pediatrics is specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. I understand that once the health information is signed, I may in the future authorize to be disclosed to someone else, reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected by the HIPAA Privacy laws.

Important Information when Transferring Care

I understand that as of the date I signed below, the above named patient will no longer receive care from Arundel Pediatrics, PA. This includes regular, evening, and weekend appointments or telephone calls including after hours calls. If the patient is interested in returning to Arundel Pediatrics, PA in the future as a patient, they may only do so if the practice is accepting new patients.

Fee for Copying Medical Records

Your prior health care provider, as well as Arundel Pediatrics may charge fees for the photocopying of your records. Please inquire of them what their fees are for this service.

Signature: _____ **Date:** _____
(Patient, Guardian *, or Authorized Representative*----- *Please provide documents to prove authority to sign on behalf of the patient)

If you are requesting this release of Medical Information and are not the parent or Guardian please specify below who you are and the facility or organization you are requesting disclosure for _____

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED